MEDICAID

MONTANA MEDICAID CERTIFICATE OF MEDICAL NECESSITY

DURABLE MEDICAL EQUIPMENT AND SUPPLIES (Rev.,Jul 99)

EPSDT NUTRITIONAL SERVICES

(FOR INDIVIDUALS UNDER AGE 21)

PATIENT NAME, ADDRESS, TELEPHONE NUMBER, DATE OF BIRTH	PHYSICIAN NAME, ADDRESS, TELEPHONE NUMBER
MEDICAID I.D. NUMBER:	MEDICAID PROVIDER NUMBER:

DIAGNOSIS: HEIGHT: WEIGHT:

PROGNOSIS: EST. LENGTH OF NEED (# OF MONTHS): 1-99 (99 = LIFETIME)

1. Description of Functional Impairment

___ Malabsorpion ___ Swallowing Impairment ___ Hyper metabolic ___ Impaired Consciousness
___ Non-functioning GI Tract ___ Intestinal Obstruction ___ Aspiration ___ Other _____
___ Mental Incapacity ___ Nausea/Vomiting

2. Current residence: (circle the appropriate) Home; Nursing Home; Hospital Rehab Unit; Institution; Group Home; Other _____

3. How many days per week administered? (Enter 1-7)

4. List product names with the number of calories per day for each product:

5. Method of administration: Syringe Gravity Pump Does not apply

6. Does patient have a documented allergy or intolerance to semi-synthetic nutrients? Y / N

7. Narrative description of **ALL** items, accessories, options and special additives ordered to include amounts: (If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document.)

Y / N ADDITIONAL ATTACHMENTS ARE INCLUDED

I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

MONTANA
Department of Public Health & Human Services